This project was completed by Rural Health Solutions, St. Paul, Minnesota, www.rhsnow.com, and funded by the Wyoming Department of Health, Rural and Frontier Health Division, Office of Rural Health, Medicare Rural Hospital Flexibility Program through a grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Public Health Service, Office of Rural Health Policy.

August 31, 2008

Many thanks to Wyoming hospitals, Wyoming healthcare providers, Wyoming Department of Health Office of Rural Health and Office of Emergency Medical Services, Wyoming Hospital Association, Mountain-Pacific Quality Health Foundation, local EMS agencies, Wyoming community healthcare providers, and other Wyoming Flex Program stakeholders for their contributions to this report.

For additional information about the Wyoming Flex Program contact Sharla Allen at the Wyoming Department of Health, Rural and Frontier Health Division, Office of Rural Health at 307/777-7293 or Sharla.Allen@health.wyo.gov

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Executive Summary

An evaluation of the Wyoming Medicare Rural Hospital Flexibility (Flex) Program occurred from January – August 2008. Approximately 65 state and local stakeholders participated in the evaluation. This report documents the evaluation methods, findings, and outcomes and makes recommendations to advance Wyoming's Flex Program.

Rural Health Solutions, a rural health program development and research firm located in St. Paul, Minnesota, conducted the Wyoming Flex Program evaluation and prepared this report. Activities conducted as part of the evaluation included: key informant interviews, Critical Access Hospital (CAH) site visits, community healthcare provider survey, and program documentation review. The evaluation incorporates information from prior evaluation activities in Wyoming, as well as information available through the national Flex Program Monitoring Team.

The Wyoming Flex Program is administered by the Wyoming Department of Health, Rural and Frontier Health Division, Office of Rural Health. During the past nine years, the Wyoming Flex Program obtained $3,564,491, or an average of $396,055 per year, from the Health Resources and Services Administration, Office of Rural Health Policy, to implement the Flex Program in Wyoming. It is the 34th highest funded program nationally. Wyoming has 14 CAHs and two hospitals eligible for CAH status, one of which is pursuing CAH status. Over the past nine years, the Wyoming Flex Program has focused on CAH designation, supporting and sustaining CAHs, EMS, quality improvement, and rural health planning as a part of its program activities.

Evaluation results indicate that the Wyoming Flex Program struggled in the initial program years. Significant strides have been made toward meeting the national program requirements of converting small rural hospitals to CAH status and supporting and sustaining CAHs, EMS integration, and quality improvement in CAHs. However, limited evaluation work has occurred. While some CAHs report they received technical assistance and grants from the Flex Program to convert their hospital to CAH status, most report they are currently receiving support as a CAH. CAHs most frequently report that the greatest accomplishment of the state's Flex Program has been the development of the Wyoming CAH Network (WCAHN) and all report they have benefitted financially from CAH status. Some of the state's Flex Program stakeholders report they have little knowledge of the Flex Program, some report they recently learned about the Flex Program through the state's Rural Health Planning process, and some are fully informed of the Flex Program and its goals. All state stakeholders are aware that some of Wyoming's rural hospitals have converted to CAH status.

A couple of key themes emerged throughout the evaluation process which should be highlighted, including: 1) hospital administrator turnover in CAHs, Flex Program staff turnover, and Wyoming Hospital Association staff turnover have reportedly had a negative impact on the Flex Program and its work; however, recent stabilization in reportedly "highly qualified" staff are seen as positive opportunities for the Flex Program; 2) the WCAHN has reportedly made little progress since its development; however, all stakeholders continue to view the network as one of the Flex Program's greatest successes and as a significant opportunity for supporting and sustaining CAHs in the state; and 3) Wyoming has a strong EMS system and local EMS agencies and CAHs have good working

relations, all of which can be built upon and developed to further integrate CAHs and EMS and improve quality of care.

Although the Wyoming Flex Program has achieved much over the past nine years, program changes are recommended to further support and sustain CAHs, improve and integrate emergency medical services, and improve quality of care. Therefore, in order to continue to advance the goals of the national Flex Program, it is recommended that Wyoming [1]:

1) Continue to educate key program stakeholders about the Flex Program and its intended goals. Although many Flex Program stakeholders are aware of the Flex Program and enhanced their program knowledge through the rural health plan development process, the need to educate stakeholders about the program continues to exist. More specifically, there is some confusion about the goals and objectives of the Flex Program, the role of the rural health plan, who should be engaged in the Flex Program, the role and activities of Bainbridge and Associates, and the difference between the rural health plan and the WCAHN strategic plan. This should be clarified, particularly given the regular turnover in CAH administrators, the current development of the WCAHN, and the number of projects contracted to other organizations.

2) Continue the Flex Program planning process. A strategic direction has been identified for Wyoming's Flex Program through the state's rural health planning process. In order to sustain this momentum and to increasingly engage stakeholder involvement and buy-in, regular program planning should occur, preferably on an annual basis, most likely in coordination with WCAHN. Not only will this allow for on-going education and information sharing about the Flex Program, but it will assure stakeholder involvement in the planning and decision making process, educate new staff as they join stakeholder organizations, increase networking between stakeholder organizations, and continue to assure the Flex Program is leveraging the resources of other organizations to better advance its goals. In addition to stakeholder groups already engaged in the Flex Program planning process, local and state EMS stakeholders should be included to assure this component of the program is fully planned and implemented to meet local challenges and opportunities.

3) Establish a formal Flex Program communications plan. A Flex Program communications plan should be discussed as part of the program strategic planning process and should report on program activities, changes, and updates relevant to all program stakeholders, including those representing EMS. Other communications issues to consider include assuring all items funded by the Flex Program are identified as such, and developing a Flex Program logo or another visual means to indicate whether workshops, tools, and other items were developed through funding from the Flex Program. Other considerations are enhancing the program's Web presence and creating a Flex Program annual report that reports program activities, outcomes, and planned next steps.

[1] The descriptive list of recommendations is included in Section 9: Recommendations.

4) Further the Use of Information Technology. Given the large geographic distances between Flex Program stakeholders, careful considerations should be made to how best use information technology (IT) and in particular health information technology (HIT) to bridge the geographic divide. Some Flex Program stakeholders have extensive experience with HIT while others are in the early stages of its use. Creating opportunities to experiment and pilot HIT initiatives has the potential to greatly enhance stakeholder participation in Flex Program activities, further the WCAHN, advance the use of electronic medical records, and improve program communications and partnering.

5) Investigate and respond to key CAH issues. Although this evaluation identifies many rural health related challenges and concerns that could be addressed as part of the Wyoming Flex Program, a few are particularly relevant to advancing the national Flex Program goals, including: creating opportunities for Bainbridge and Associates to collaborate with Mountain-Pacific Quality Health Foundation on quality and performance related projects, identifying best practices and providing support toward CAHs increasing their market share, supporting performance improvement educational opportunities for CAHs and EMS agencies, and addressing the HIT and workforce needs and challenges facing CAHs. In addition, Wyoming is unique in that it has EMS agencies either located or considering locating in CAHs that are more than 35 miles from the next nearest EMS agency. This should be further explored to better understand the challenges and opportunities of these CAHs and EMS agencies and how the Flex Program can best support them.

6) Monitor and evaluate Flex program outcomes within the context of program planning and implementation with predetermined goals and outcome measures. Program measures and targets included as part of the state's rural health plan should be tracked and used to better measure and report Flex Program outcomes. This can be built into the program planning process and reported as part of the recommended Flex Program annual report. In addition, regular site visits should be made to CAHs and local EMS agencies. Site visits should include a variety of hospital staff such as hospital administrators, chief financial officers, chief nursing officers, quality improvement coordinators, and others as appropriate. Finally, the Wyoming Flex Program should use the financial reports completed by the Flex Monitoring Team for WCAHN planning and on-going monitoring of the financial status of Wyoming CAHs. This is an efficient means of tracking and the reporting hospital's financial strengths, challenges, and viability.

Section 1: Evaluation Methods

This section of the evaluation describes the methods that were used to collect, analyze, and report evaluation information. It focuses on intended evaluation goals, outcomes, data collection methods, and those involved in the data collection process.

A. GOALS

- The Wyoming Medicare Rural Hospital Flexibility Program (Flex Program) evaluation was a nine-month project that included one survey, 16 key informant interviews, four CAH site visits and staff interviews, and a review of program documentation. The goals of the Wyoming Flex Program evaluation were to:
- Measure satisfaction with activities performed at the state level, in CAHs, and communities;
- Identify stakeholder involvement in the development and implementation of the Flex Program;
- Determine consistency of program goals and how they are meeting state and national Flex Program goals and objectives;
- Report specific CAH and community outcomes as they relate to CAH designation and other aspects of the Flex Program;
- Identify program strengths and weaknesses; and
- Make recommendations for on-going program development and improvement.

In addition, the evaluation was designed to answer several key questions:

- What do Wyoming's Flex Program participants know about the Program and its opportunities?
- How has rural health in Wyoming changed since the Wyoming Flex Program was implemented?
- What partnerships have evolved because of the Wyoming Flex Program?
- What have been some of the greatest Wyoming Flex Program accomplishments and who has been affected?
- How could the Wyoming Flex Program change to better meet the needs of its stakeholders?

As part of the evaluation process, Rural Health Solutions' staff spent seven days on-site in Wyoming reviewing documents, collecting data, meeting with and interviewing state Flex Program stakeholders, visiting CAHs, interviewing CAH staff, and interviewing local EMS directors. All data collected has been aggregated for reporting purposes. Anonymous quotes from the evaluation process are used to provide additional insight into program involvement, activities, outcomes, and recommendations.

B. CAH SITE VISITS AND CAH ADMINISTRATOR INTERVIEWS

CAH site visits and CAH administrator interviews were conducted to maximize the number of CAHs included in the evaluation process, as well as to assure all aspects of the Flex Program could be discussed with CAH staff. Four Wyoming CAHs were visited from May 19 – August 10, 2008, as part of the CAH site visits. At each site and when available, staff serving as hospital administrator, chief financial officer, chief information officer, director of nursing, quality improvement coordinator, and local EMS director were interviewed. In many instances, one staff person served in two or more of these roles. A total of 13 staff were interviewed at all four sites. Nine CAH administrators were also interviewed via telephone as part of the CAH administrator key informant interviews.

Interview questions of CAH staff included:

- General satisfaction with CAH conversion assistance
- Knowledge of program stakeholders and services
- Use of and satisfaction with the technical assistance, tools, and resources provided by the Wyoming Office of Rural Health and other state Flex Program stakeholders
- Use of grant funding
- EMS and networking improvement activities and needs
- CAH quality of care and performance improvement activities
- Outcomes that may have resulted due to QI programs/projects
- Role of the Wyoming Flex Program in QI programming/activities
- On-going QI needs and issues
- Changes in financial status
- Planned capital improvements/needs
- Post-CAH conversion issues and concerns

C. STATE STAKEHOLDER INTERVIEWS

Seven Wyoming Flex Program state stakeholders (Table 1) were interviewed using a set of questions to: 1) measure their satisfaction with program operations, management, and implementation; 2) discuss their involvement in the development of the Flex Program; and 3) identify Flex Program planning, development and implementation needs and next steps. Interviews occurred between June 9 and August 14, 2008. When possible, interviews were conducted in person.

Table 1: State Flex Program Stakeholders

Organization	Name	Interview Site
Wyoming Department of Health, Office of Rural Health, Flex Program	Sharla Allen	In-person
Wyoming Department of Health, EMS Programs	Jim Mayberry	In-person
Wyoming Hospital Association	Dan Purdue	In-person
Wyoming Hospital Association	Steve Bahmer	In-person
Mountain-Pacific Quality Health Foundation	Jan Pope	Telephone
Wyoming Health Resource Network	Pennie Hunt	Telephone
Wyoming Health Quality Center	Edna Rensing	Telephone

Note: Mountain Pacific Quality Health Foundation is the state's Quality Improvement Organization (QIO)

An additional preliminary interview was conducted with Sharla Allen, Wyoming Department of Health, Rural and Frontier Health Division, Office of Rural Health, Office of Rural Health Manager and Flex Program Coordinator, to gather program information as part of the evaluation planning process.

D. COMMUNITY HEALTHCARE PROVIDER SURVEY

The Community Healthcare Provider Survey was a mailed survey that was conducted between June 1 and July 31, 2008, in five Wyoming CAH communities. Eighty-seven healthcare providers based in CAH communities were surveyed, including: physicians, chiropractors, local public health directors, dentists, mental health providers, nursing home administrators, home health care directors, assisted living center directors, optometrists, pharmacists, and alternative health providers. The number and type of providers surveyed varied across communities; however, physicians were the most frequent survey respondents. The survey response rate was 29 percent. The Community Healthcare Provider Survey was conducted to determine community provider: 1) knowledge of and involvement in the hospitals' conversion to CAH status, 2) changes in practice patterns, referrals, and utilization due to CAH conversion, 3) perceptions of the CAHs' quality of care, 4) vertical networking activities, 5) community healthcare strengths, weaknesses, issues and concerns, and 6) current and on-going community health planning activities.

E. PROGRAM IMPLEMENTATION DOCUMENTATION

Program implementation information was reviewed to provide a historical perspective of Wyoming's Flex Program's development and funding support and to identify the roles of entities involved. The review also shed light on the relationships between program implementation activities and program outcomes. Information collected and reviewed included:

- Wyoming Rural Health Plan, March 2000
- Wyoming State Rural Health Plan, October 2001
- 2001, 2003, 2004, 2005, 2006, and 2007 Wyoming Grant Applications for federal Flex Program funding
- Wyoming CAH Networking meeting information
- Contractual requests from CAHs for Flex Program funding
- Annual reports from the Wyoming Department of Health, Office of EMS
- EMS funding requests and awards made by the Wyoming Department of Health, Office of EMS
- South Big Horn County Hospital, Basin, Wyoming, Financial Feasibility of Re-opening as a CAH, Rural Health Consultants, Inc., July 19, 2000
- South Big Horn County Hospital District, Basin, Wyoming, CAH Community Needs Assessment, Rural Health Consultants, Inc., June 1, 2000
- Multistate Performance Improvement Project information, Kansas Rural Health Options Project
- QHi information, Kansas Rural Health Options Project
- Medicare Rural Hospital Flexibility (Flex) Program 2005 Critical Access Hospital Survey, Summary of Results, Wyoming Department of Health, Office of Rural Health, May 2005
- Flex Program Meeting Evaluation Summaries and related survey responses from attendees
- Other program documentation

Section 2: Flex Program Summary

This section of the evaluation provides an overview of the Wyoming Flex Program, rural health in Wyoming, the administration of the Flex Program, program funding and allocations, and a description of program activities. Information included in this section was obtained from resources on the Internet; Wyoming Flex Program staff and other program stakeholder interviews; program documentation; the Health Resources and Services Administration, Office of Rural Health Policy Website; and the Flex Program Monitoring Team Website.

A. OVERVIEW

The Medicare Rural Hospital Flexibility Program (Flex Program) was established through the Balanced Budget Act of 1997. It is a national program that includes 45 states, including Wyoming. In essence, the Flex Program is comprised of two components – grants to assist states in implementing state specific program activities and an operating program that provides cost-based Medicare reimbursement to hospitals that convert to CAH status. The U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), federal Office of Rural Health Policy (ORHP), administers the grant program. The operating component of the program is administered by the Centers for Medicare and Medicaid Services (CMS), also located within DHHS.

Six Flex Program priority areas have been established for states implementing the program:

- Developing a state Rural Health Plan
- Designating and supporting CAHs
- Developing rural health networks
- Integrating Emergency Medical Services (EMS)
- Improving the quality of healthcare
- Evaluating Flex Program activities and related outcomes

The Wyoming Flex Program currently focuses on all aspects of the Flex Program. It features activities that are implemented by the Wyoming Office of Rural Health, along with a number of contractual agreements with program partners.

As of August 2008, Wyoming has 14 CAHs, below the national average of 28.5 CAHs per state.[2] Fifteen other states have fewer CAHs than Wyoming. Over the past nine years, the Wyoming Flex Program has directed the majority of its federal funding to supporting and sustaining CAHs. This assistance has been in the form of workshops/training, technical assistance, and contractual arrangements with CAHs. The remaining funding has supported:

- CAH conversion related activities
- Planning, development, and operations of the WCAHN
- EMS grants for equipment and supplies
- EMS electronic reporting system
- Trauma system development
- Telehealth initiatives
- State Rural Health Plan development
- Quality Improvement initiatives
- Program evaluations

B. RURAL HEALTH AND WYOMING[3]

Wyoming is located in the western United States and is dominated by the High Plains and Rocky Mountains. It is the least populated state in the nation while it is also the 9th largest in size. Wyoming has 23 counties and 48 percent of its land is owned by the U.S. Government. Among many things, it is known for Yellowstone National Park, Grand Teton National Park, and Devils Tower National Monument. Wyoming has unique and often extreme weather patterns, outdoor recreational activities, dude ranches, and large numbers of hot springs. Wyoming was admitted as the first state that allowed women to vote.

[2] As reported on the Flex Monitoring Team, April 2008, www.flexmonitoring.org.

[3] Sources: Wikipedia online at www.Wikipedia.com, U.S. Census Bureau at www.census.gov , and www.wyomingtourism.org.

Wyoming's total area is 97,914 square miles. Its geography can be characterized by its short grass prairies, cacti, shrub grasses, low moisture and high elevation, and its vast mountain ranges. It is bordered by Montana, South Dakota, Nebraska, Utah, Idaho, and Colorado. Wyoming has no dense urban areas, with the capitol of Cheyenne having the largest population of 55,731 and serving as one of the state's two metropolitan statistical areas (MSA). Other "large" cities in the state include: Casper (51,738 and the other MSA), Laramie (26,050) and Gillette (22,685).

In 2007, Wyoming was estimated to average 5.4 persons per square mile, compared to the U.S. average of 79.6 persons per square mile. Wyoming's population density is the second lowest in the U.S. (the lowest being Alaska). According to the U.S. Census Bureau, the population of Wyoming is estimated as 522,830, of which 69.8 percent are rural, approximately 25 percent have German ancestry, 91.8 percent are identified as "White Alone", 2.2 percent are "American Indian or Alaskan Native", and 6 percent are "Other". In addition, people in Wyoming are more likely to have a high school diploma, less likely to have a college degree, less likely to live in poverty, and less likely to be 65 years and older when compared to the nation as a whole.

The greatest contributors to Wyoming's economy are mineral commodities such as coal, natural gas, and crude oil; tourism; and agricultural commodities such as beef and sugar beets. Wyoming ranks 22nd nationally in terms of median household income and 46th nationally in terms of the percent of people living in poverty.[4]

There are 27 acute care hospitals in Wyoming, including 14 CAHs, or 51.9 percent of the state's hospitals. Wyoming's CAHs vary in the services they provide; however, several own or operate their local ambulance service and have attached long-term care facilities. Eleven of Wyoming's CAHs meet the federal geographic criteria of the hospital being 35 miles or 15 miles in mountainous terrain or areas only served by a secondary road from the next nearest hospital. When needed, most CAHs in Wyoming refer and transfer the majority of their patients to tertiary centers in other states.

Wyoming's EMS system is based on regional and community trauma areas. There is no level I trauma center in the state. Interesting to note is that its poison control center is shared with neighboring Nebraska. There are 74 licensed ambulance services, 189 ambulances, and approximately 1,200 ambulance personnel in the state. The largest service area for any one ambulance service is 1,426 square miles. Of the ambulance personnel, 80 percent are classified as "volunteer" with approximately 450 working as emergency medical technician (EMT) – basic, 600 EMT-Intermediate, and 150 as paramedics. Approximately 80 percent of ambulance services are certified as Basic Life Support (BLS) services and 20 percent are certified as Advanced Life Support (ALS) services. There are eight EMT-B training sites in the state: one four-tier university and seven community colleges. Statewide, the number of requests for EMS services has been increasing as indicated by approximately 35,000 EMS runs in 2000, 51,000 in 2005, and 57,000 in 2007.[5]

[4] US Census Bureau, www.census.gov

[5] As reported by the Wyoming Department of Health, Office of EMS, August 2008.

C. ADMINISTRATION

The Wyoming Department of Health, Rural and Frontier Health Division, Office of Rural Health, administers the Flex Program. Staff positions supported through the Flex Program have varied over the years, but have ranged from .62 FTE (full-time equivalents) to 1.12 FTE at the Wyoming Department of Health (including times when positions were vacant). It should be noted that there has been considerable staff turnover in Wyoming's Flex Program and its State Office of Rural Health; however, this has stabilized in the last year. The positive impact of this stabilization was voiced throughout this evaluation process by both state and local program stakeholders.

Many of the state's Flex Program project activities are contracted to other organizations, such as work completed by the Wyoming Hospital Association, Wyoming Department of Health, Office of EMS, University of Nebraska, Kansas Rural Health Options Project, and Bainbridge and Associates. These organizations and consultants have completed projects related to development of the Wyoming Rural Health Plan, supporting and sustaining CAHs, EMS support, network development, and quality improvement. Given the lack of stability in Flex Program staffing, contracting work has reportedly stabilized program activities and allowed for the continuation of program work that would have been otherwise disrupted.

D. FUNDING

During the past nine years, Wyoming received $3,564,491, or an average of $396,055 per year,from the Health Resources and Services Administration, Office of Rural Health Policy to implement the Flex Program in Wyoming. [6] Wyoming ranks 34th of 45 states in terms of the federal Flex Program funding received over the nine-year period; however, it ranks 16th in terms of funding per CAH ($254,067/CAH). As displayed in Chart 1, a decrease in program funding began in 2002 with funding increases in subsequent years. The changes in program funding in 2002 are primarily attributed to 1999 – 2001, national state funding requests were below or paralleled available funding and subsequent national state funding requests exceeded available funding (an excess of $2.42 million in 2002 and $4.54 million in 2003) which resulted in greater competition for funding. [7] Prior to 2006, states were allowed to request up to $700,000 per year in federal Flex Program funding.[8] This changed to a maximum request of $650,000 in 2006.

E. FUNDING ALLOCATIONS

Wyoming Flex Program funding has been directed to: staff salaries and benefits (11.9%); travel costs (5%); EMS activities (22.7 %); CAH support, performance improvement, and network development (26.7%); quality improvement activities (8.4%); indirect charges (9.3%); and other program costs (16%).[9] During the initial program years, much of the funding supported contractual arrangements with CAHs, contractual costs for CAH conversion related activities (e.g., financial feasibility studies),

[6] www.hrsa.gov/orhp

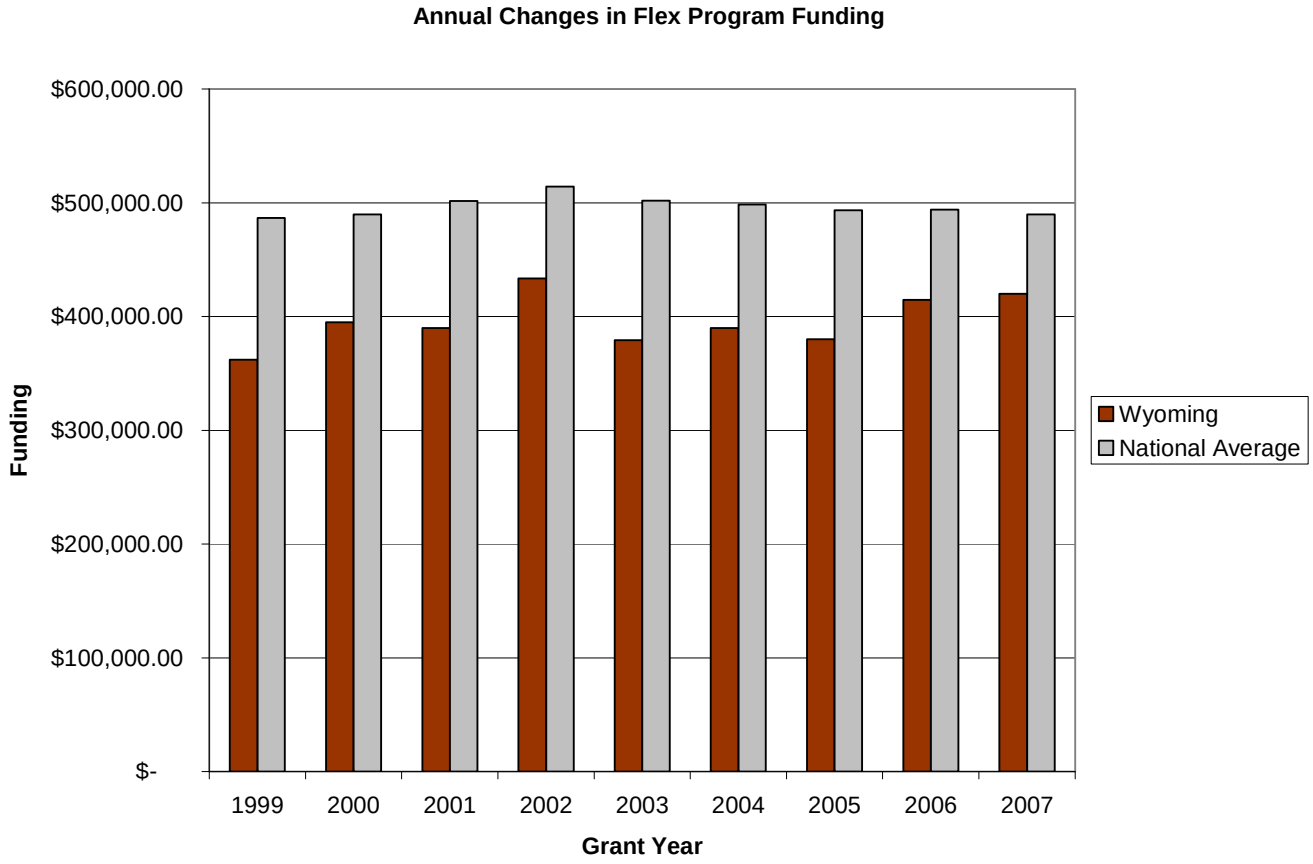
[7] "A Synthesis of State Flex Program Plans 2003-2004", Flex Monitoring Briefing Paper Number 1, Flex Monitoring Team, May 2004.

[8] Note: In 1999 and 2000 supplemental awards were made available to states.

[9] Allocations are based on Flex Program funding for the 2006 – 2007 grant year.

and EMS equipment and supplies. During the past three years, funding has been directed to Flex Program goals associated with quality improvement, network development, EMS integration, and supporting and sustaining CAHs.

Chart 1: Annual Federal Funding of Wyoming's Flex Program as Compared to the National Average for all States



F. PROGRAM ACTIVITIES

An overview of Wyoming's Flex Program activities, based on national Flex Program priority areas, is included in this section. Some of the activities are currently underway and/or being implemented as part of the state Flex Program while others were completed, as noted. Additional information related to each program goal is included later in this report.

Rural Health Planning – In Process

A Wyoming Rural Health Plan was created and approved by the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services - CMS) in March 2000. Rural Health Plan approval by the Health Care Financing Administration was the first requirement for state

participation in the Flex Program. Since most states' rural health plans were approved in early 1999, this approval date most likely had a significant impact on small rural hospitals' opportunity to convert to CAH status. A revision to the rural health plan was made in October 2001. The intent of both of these rural health plans was to "guide implementation of the Medicare Rural Hospital Flexibility Program."[10]

Since that time, the Wyoming Flex Program hosted a number of program planning meetings with CAH representatives, such as: April 10, 2003 (in-person), March 27, 2004 (teleconference), and April 27, 2004, to discuss the goals of the Flex Program and plan for program activities for the upcoming grant year.

In 2007, Wyoming started working on a new Wyoming Rural Health Plan as required by the Health Resources and Services Administration, Office of Rural Health Policy. This plan is being developed under contract with the University of Nebraska. The Flex Program is using a multi-phase process that has included approximately 20 rural health stakeholders to develop its plan. The Wyoming Rural Health Plan is planned for completion and release in 2008.

Converting Small Rural Hospitals to CAH Status – In Process

Until 2005, the majority of Wyoming Flex Program funding supported converting small rural hospitals to CAH status: 14 CAHs converted to CAH status. CAH conversion assistance was used for community needs assessments, the CAH application process, financial feasibility studies, network agreements, technical assistance with completing the CAH application process, working with survey and licensing or the state's fiscal intermediary, responding to questions as requested, and other needs as determined by CAHs.

Two hospitals continue to be eligible to convert to CAH status in Wyoming; one is currently pursuing CAH status (South Lincoln Medical Center, Kemmerer). Therefore, the Wyoming Flex Program continues to address this goal and has the tools and resources in place to address future hospital conversion needs, should they arise.

Supporting and Sustaining CAHs – In-Process

During the past few years, Flex Program funding has primarily been directed toward advancing the Flex Program goal of supporting and sustaining CAHs. This has been accomplished through contractual arrangements with CAHs, technical assistance, and support from Flex Program staff, as well as through contractual arrangements with other rural health stakeholders and consultants. Examples of on-going activities include:

- Supporting the Wyoming CAH Network (WCAHN):
  - Quarterly WCAHN meetings
  - Development of a nurse management training program
  - Strategic planning
  - Network operations

[10] As stated in the 2000 and 2001 Wyoming Rural Health Plans.

- Supporting contractual arrangements for performance improvement projects (4 grantees in 2005)
- Supporting CAH participation in the Western Regional Flex Conference, NRHA Policy Institute, National Flex Conference, NRHA Critical Access Hospital Conference, and other relevant trainings
- Providing technical assistance to CAHs on an as-needed basis

Emergency Medical Services – In-Process

Wyoming's Flex Program has supported EMS through informal arrangements with the Wyoming Department of Health, Office of EMS. This has included: EMS System Enhancement Awards, instructor payments for EMT-Intermediate classes, annual trauma registry site licenses fees for all hospitals in the state, EMT and nurse continuing education opportunities, trauma registry training, subsidies for statewide and regional trauma meetings, as well as other activities. Unlike most states, EMS support has been a significant part of the Wyoming Flex Program since 1999.

The EMS System Enhancement Awards were an opportunity for local EMS agencies to engage in contractual arrangements of up to approximately $2,500 (depending on Flex Program grant year) to purchase equipment and/or supplies. This was an on-going Flex Program activity that ended in 2007.

Instructor and local coordinator payments for EMT-Intermediate classes are made available through the Office of EMS to support advanced life support training in rural communities. This has resulted in enabling approximately 95 percent of ambulance services in Wyoming to offer advanced life support services.

Regional and state trauma meetings are supported through the Flex Program by funding and subsidizing participants' travel costs, meeting room rentals, and supplies. Flex Program funding is also used for hospitals' annual trauma registry site license renewals, technical support, and software upgrades. Both are on-going Flex Program activities.

Quality Improvement (QI) – In-Process

Quality improvement activities funded through the Wyoming Flex Program include performance improvement grants to CAHs, a multi-state quality improvement collaborative aimed at CAHs, and QI status assessments. Performance improvement (PI) grants of up to $20,000 were made available to CAHs in 2005. Two of the CAHs that applied for funding used their grants for staff training and chronic disease prevention. A current Wyoming Flex Program QI activity is Quality Health indicators (QHi), a multi-state, benchmarking, QI initiative managed by the Kansas Flex Program. This on-going project began in 2006. Three CAHs indicate they report data to QHi. The Flex Program is also starting a QI assessment process that is to lead towards implementation of QI/PI. Assessments are occurring over a two-year period starting in 2007.

Network Development – On-going

The Wyoming Flex Program has supported informal networking opportunities through its meetings, conferences (including the Western Regional Flex Conference), workshops, and formal networking activities through the planning, development, and implementation of the WCAHN. All networking activities are considered on-going Flex Program activities.

Program Evaluation – On-going

Wyoming has evaluated different aspects of its Flex Program over the past nine years; however, this work has been limited. Most evaluation work has occurred at the activity level (e.g., conference satisfaction surveys) while a survey of CAH administrators was conducted in 2005 to determine their satisfaction with the Flex Program. The current Flex Program evaluation~~,~~ is reflected in this report and is the first full Flex Program evaluation completed as part of the Wyoming Flex Program.

Section 3: Critical Access Hospitals (CAHs)

This section of the Flex Program evaluation focuses on findings from the CAH site visits and CAH administrator key informants interviews related to CAH conversion, support, and current issues and needs. In particular, it outlines evaluation findings related to CAH:

- Designations
- Leadership
- Conversion Assistance
- Decision to Convert
- Programmatic and Grant Support
- Changes in Services and Providers
- Electronic Medical Records
- Networking
- Community Health Care Providers' Working Relations with CAHs
- Post-conversion Opportunities, Challenges, and Needs

Information included in this section of the report was obtained through: 1) CAH staff interviews and site visits, 2) interviews with local, state, and regional EMS stakeholders, 3) state stakeholder key informant interviews, 4) materials from state stakeholders, 5) Flex Program reports, and 6) national Flex Program Monitoring Team Website and reports.

A. CAH DESIGNATIONS

14 CAHS

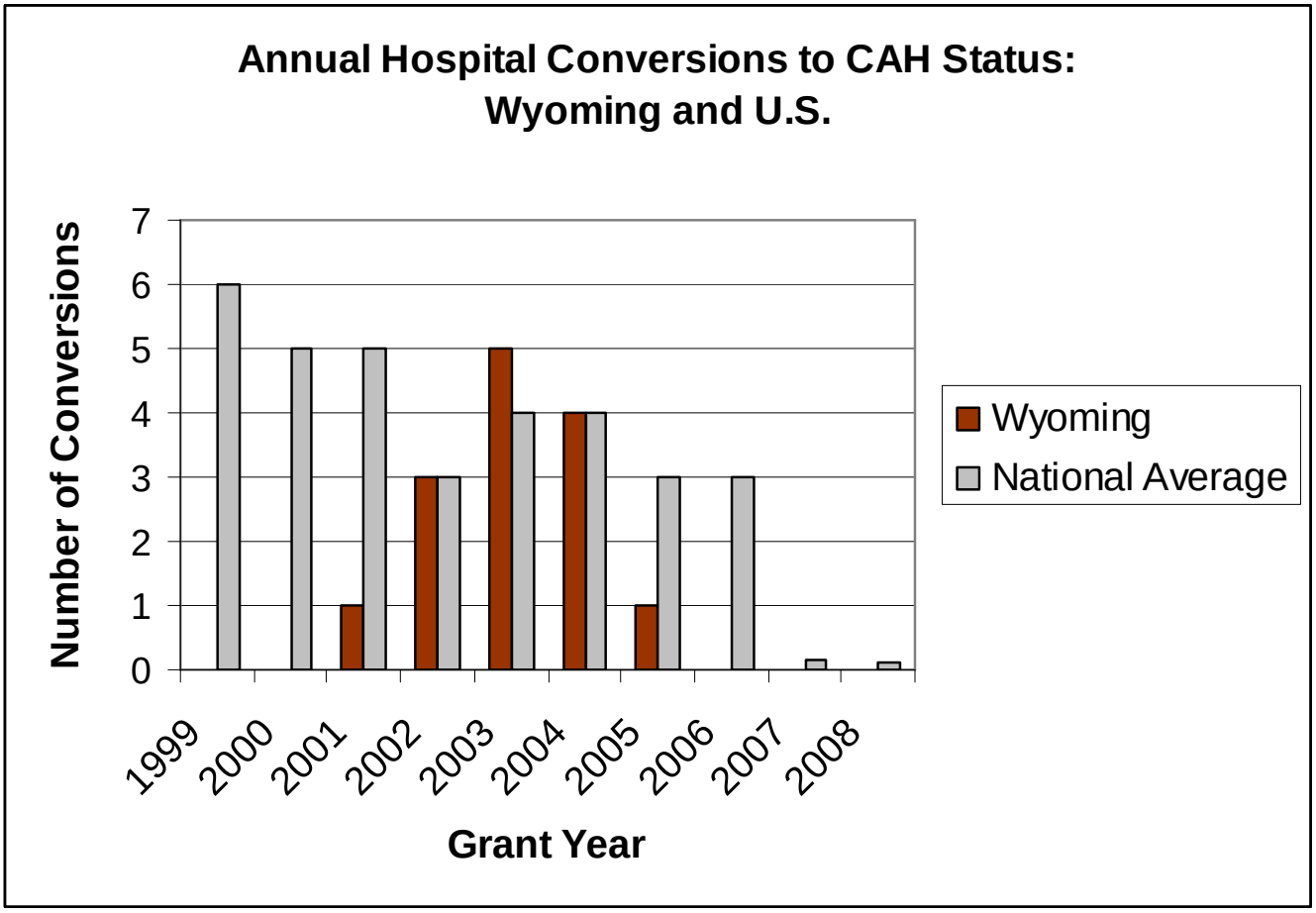
Fourteen hospitals, 51.9 percent of Wyoming's acute care hospitals, have converted to CAH status. Two hospitals continue to be geographically eligible for conversion and one is pursuing CAH status. No CAH was identified that is considering converting back from CAH status. Wyoming CAHs do not receive cost-based reimbursement for Medicaid.[11] Eleven CAHs in Wyoming are more than 35 miles from the next nearest hospital or 15 miles from a hospital in an area with only a secondary road or with mountainous terrain.

As shown in Chart 2, Wyoming's small rural hospitals started converting to CAH status much later than those nationally. This is likely a reflection of when the state's original rural health plan was

[11] Approximately half of all states with CAHs reimburse CAHs for Medicaid services on a cost basis..

completed and approved (a requirement for program participation), which was approximately one year after most states.

Chart 2: Number of Wyoming Hospitals that Converted to CAH Status in Relation to Each Flex Program Year and Compared to the National Average of CAH Conversions



Source: Flex Monitoring Team, August 2008.

B. CAH LEADERSHIP

As stated earlier in the report, site visits were made to four CAHs in Wyoming. Key informant interviews were conducted with hospital administrators in all but one CAH. These interviews found that CAHs have leadership with experience working in CAHs and Flex Programs in other states (South Dakota, Montana, and Idaho), in different hospital systems, and with different years of service (e.g., one hospital administrator was serving in an interim role, one had been in the hospital approximately 30 years). For those staff leaders that have been in the CAH for at least five years, most reported they participated in their CAH conversion process, including: conducting background research about the program, obtaining hospital board approval, initiating/completing the CAH

application process, project management, coordinating the survey and licensing process, and/or delegating conversion activities to hospital staff.

C. CAH CONVERSION ASSISTANCE

As part of the CAH site visits and CAH administrator interviews, CAH staff were asked to report on the CAH conversion technical assistance and other support (e.g., financial) they received through the Flex Program. Findings from those discussions are reported below:

Most CAH staff report:

- Receiving funding through the Flex Program to complete community needs assessments, financial feasibility studies, and network agreements
- The CAH conversion process took approximately one year
- Receiving much of their CAH conversion technical assistance from other CAHs in Wyoming and other states

Some CAH staff report:

- Receiving technical assistance from Flex Program staff during the CAH conversion process
- Flex Program CAH conversion technical assistance was "really helpful" or "very helpful"
- Using the CAH community needs assessment information after their hospital's conversion to CAH status while others reported the assessment was completed purely as a requirement for conversion to CAH status
- Having extensive issues with United Government Services, the state's fiscal intermediary (FI), including working with FI staff that are not familiar with CAHs and CAH requirements
- Poor communications with CAHs about the Flex Program and opportunities to assist them with converting to CAH status
- Needing to address issues related to physician support, changing policies and procedures, and/or changing their organizational structure in order to convert to CAH status

"Without a doubt, it was an excellent decision [to convert to CAH status]."

- CAH Staff

Other Information:

- Three CAHs surveyed in 2005 and three CAHs interviewed in 2008 reported their hospital received no technical or financial assistance as part of the CAH conversion process

D. CAH DECISION TO CONVERT

As part of the CAH site visits, CAH staff were also asked to report on their hospital's decision to convert to CAH status. More specifically, they were asked if converting to CAH status was a good decision, ok decision, poor decision, and why. Findings from those discussions are reported below:

"As a CAH we have access to the Flex Program and additional support from the state just because we are associated with the Flex Program. It's been great."

- CAH Staff

All CAH staff report:

- Their decision to convert to CAH status was primarily a financial decision
- Conversion to CAH status was the right decision for their hospital

Most CAH staff report:

- Converting to CAH status was an "excellent" or "good" decision

E. CAH PROGRAMATIC AND GRANT SUPPORT

Once converted to CAH status, the Flex Program has supported CAHs through a variety of programs, technical assistance, meetings and workshops, and grants. Therefore, during the CAH site visits, CAH staff were asked to report on their satisfaction with, use of, and outcomes resulting from this support. Information was collected on program support provided with a focus on activities/projects that have been funded during the past two years. Findings are included here.

"I'd never seen a Flex Program grant application until last year."

- CAH Staff

<u>State Meetings and Conferences</u>:

- Most CAHs report meetings and conferences have improved over the years; however, many CAHs report they do not consistently attend these meetings
- Some CAHs report a need for the Flex Program to consult with CAH staff about meeting and workshop agendas and intended outcomes to assure they best meet CAH needs
- All CAHs report meetings are a good opportunity for CAHs to network
- Some CAHs report the state rural health planning meeting was a good opportunity to learn about the Flex Program, related opportunities, and to plan for the state Flex Program

"I was very impressed that they said, we think all of your input is important [referring to the rural health plan development process]. They are allowing us to have a huge voice and I appreciate that.."

- CAH Staff

<u>Grants</u>:

- One CAH reports they upgraded their radio communication systems in the ER

- One CAH reported they increased hospital security by completing security system upgrades and reissuing staff IDs to open interior and exterior doors
- One CAH reported receiving support for CAH training as part of a national CAH conference
- One CAH reported their recently completed community needs assessment has helped them to identify their patients' transportation needs, additional healthcare services needs, and some changes that should be made to the hospital's physical plant
- Four CAHs received grants through the Performance Improvement Grant Program to address financial/operational issues, such as completing charge master reviews
- Flex Program funded grant activities were reportedly, "very helpful" or "not possible" without grant funding

"I really appreciate that she [Flex Program Coordinator] tried to learn what is going on before just moving forward [referring to the state rural health plan.]"

- CAH Staff

Milliman:

- All but one CAH that started Milliman through the Flex Program continue to use it
- CAHs report Milliman has improved their admissions and discharge processes
- Some CAHs are not familiar with and/or have not used Milliman

Technical Assistance:

- Most CAH staff report that in the past two years, technical assistance from the Flex Program has increased
- Some CAH staff report that the high turnover in Flex Program staff has had a negative impact on the Flex Program and its staff's expertise/ability to provide technical assistance and support to CAHs
- Some CAH staff report that in prior years, more Flex Program funding was directed to CAHs in the form of grants and they found this preferable to current program activities
- Some CAH staff report they receive more technical assistance from other CAHs, as compared to the Flex Program

"I know the Wyoming Flex Program is out there but that is about it."

- CAH Staff

Rural Health Plan Development:

- CAHs report they support the development of the state rural health plan and they believe this was a valuable activity

Other Comments/Items to Note About Flex Program Technical Assistance and Support:

- "I hope there can be a better organizational structure for the Flex Program so it can actually assist CAHs"
- "Things have really changed in the last couple of years. Now we can actually get support"

- "The hospital association (WHA) was never involved much in the Flex Program and I think that has not helped our CAHs"

F. CHANGES IN CAH SERVICES AND HEALTHCARE PROVIDERS

Access to health services is often defined in terms of service availability, healthcare provider availability, distance/travel times, and affordability/cost. A primary intent of the Flex Program is to maintain and improve access to rural health services. Considering this and the impact that CAH conversions may have had on access to services, the evaluation gathered information on changes in CAH services and the availability of healthcare providers as part of the CAH site visits and CAH administrator key informant interviews. Using this information, there were indications that some CAHs have eliminated hospital services while the majority have added and/or upgraded services and their mix of healthcare providers. Most CAH administrators that report services were eliminated did not attribute the loss in services to conversion to CAH status; rather, they attribute it to limited volume, quality of care, access to other service providers in the community, reimbursement issues, and/or provider recruitment issues. For those CAH administrators that report adding services, they attribute the new/expanded services to community need, increased market share, the financial stability of the hospital, and/or the availability of resources to purchase equipment needed to provide/enhance the service.

Below are lists of services that were added, updated, or eliminated in CAHs as reported by CAH staff.

"There is no way we could have done all of this [upgrades in services and equipment in the hospital] without CAH status. We were losing $1.2 million per year."

- CAH Staff

<u>Services Added/Updated:</u>

- Specialists (e.g., orthopedic surgeon)
- Respiratory therapy
- Physical therapy
- Occupational therapy
- Added long term care beds
- Hospital physical plants
- Lab
- Ultrasound
- Computed tomography (CT)
- Radiology
- Echo cardiograms
- Picture Archiving and Communication System (PACS)
- Chemotherapy
- Alzheimer's specialty care unit
- Rural Health Clinics
- EMS
- EMS changed from EMT-Intermediate to paramedic service
- Sleep lab
- Digital services (mammography, MRI, CT, and radiology)

Services Eliminated:

- Outpatient surgery
- Other surgery services (due to loss of surgeons)

Other Activities or Comments to Note:

- Some CAHs report they were Joint Commission accredited prior to CAH conversion but terminated this during conversion. They note this may not have been a direct result of CAH status, but an opportunity to decrease costs
- "Cost-based reimbursement was good but it has also allowed us to provide some important services that we wouldn't provide because we were losing money or they were too expensive to even consider providing"

G. CAHS' FINANCIAL STATUS

A primary goal of the Flex Program is to support and sustain CAHs; sustainability will only occur when CAHs are financially viable organizations. Therefore, financial information was gathered through the CAH site visits and CAH key informant interviews by discussing changes in financial status and CAHs' current financial needs/issues.

"Financially it [CAH status] has been a huge success for our hospital."

- CAH Staff

CAHs' Financial Status Prior to Conversion

Examples of comments from CAH staff related to their hospital's financial status prior to CAH conversion and changes in financial status include:

- "Prior to conversion, we were in the red and barely squeaking by"
- "Before [CAH conversion] we were just barely in the black"
- "Prior to CAH we were losing money"

"Our success is based on three key changes: management, community perception, and increased reimbursement. They all tie together."

- CAH Staff

CAHs' Financial Status Post-Conversion

CAHs were asked to report indicators of financial improvements since their hospital converted to CAH status; they report:

- All CAHs report their financial status has improved since conversion to CAH status
- One hospital reported their average daily census has increased from 7 to 12. This is a result of the many changes they have been able to make at their hospital (e.g., adding services)
- One hospital reported they have changed from having no cash-on-hand to $4 - $5 million in cash reserves
- Most CAHs report CAH status has had a positive impact on their cash flow which allows them to plan and address needs more proactively
- Most CAHs report the additional reimbursement from CAH conversion has allowed their hospital to upgrade "desperately" needed equipment (e.g., CT scanners)
- Some CAHs report cost-based reimbursement has allowed their hospital to upgrade its physical plant

- Some of the CAHs report an increase in acute and swing bed days, while most CAHs report an increase in outpatient visits since conversion to CAH status
- Some CAHs report a decline in acute inpatient utilization

Other Comments Reported About CAHs' Changes in Financial Status:

- "We owe all of these great changes to cost-based reimbursement"

CAHs' Capital Improvements

While most CAHs have made capital improvements to their physical plants since conversion to CAH status, some continue to explore remodeling, new-build, and additions to their current space. Examples of spaces to be remodeled or added include: laboratory, emergency rooms, radiology departments, physical and occupation therapy, areas in long term care, and clinic space. Two CAHs report they are working on master facility planning projects.

H. CAH ELECTRONIC MEDICAL RECORDS

Electronic medical records are becoming a standard tool used in healthcare facilities across the U.S. To better understand the electronic medical record (EMR) status and needs of Wyoming's CAHs and to gather baseline data for future tracking and reporting, CAH staff were asked questions about their hospital's status of planning, purchasing, installing, and training staff on an Electronic Medical Record (EMR). They reported the following:

"The docs were resistant but the day is quickly coming when everyone will like it [EMR]."

- CAH Staff

CAH EMR Status

- Planning process
  - Most CAHs are reportedly in the EMR planning process
- Implementation Process
  - Seven CAHs are reportedly in the EMR implementation process
  - Products identified during the evaluation include:
    - Dairyland[12]
    - Cerner
    - CPSI

CAHs that are part of a system report they have a more advanced EMR implementation process as compared to independent CAHs.

Other Thoughts and Comments Regarding CAHs' EMRs:

- "Wyoming tends to be autonomous and we need to be careful because we need to connect with the rest of the world."
- "We don't want to invest in something that we cannot communicate with."

[12] Most common EMR identified being used by or being considered by CAHs.

- "We have done the planning and have a good idea of what we need, but we have questions about what will meet those needs"
- "I think we need an EMR for recruiting purposes. Pretty soon no one is going to want to come here because we don't have an EMR"

I. CAH NETWORKING

A requirement for CAH designation is to have a network agreement in place for referral and transfers of patients to other hospitals; in particular, tertiary centers. At the time of CAH certification, all Wyoming CAHs had, at a minimum, the required networking agreements in place with a referral hospital. As part of the CAH site visits and CAH administrator key informant interviews, CAHs were asked to comment on their network arrangements and any outcomes that have resulted because of the new networking relationships. CAH staff primarily commented on the systems in which their hospital is a member, or the referral and transfer of patients to larger tertiary centers. In most instances they report that the affiliation/relationship with their system/network increased after conversion to CAH status. Most attribute the changes in these relationships to the improved financial status of the CAH. Outcomes that have resulted due to improved network relations include increased access to: system resources/expertise, staff support, group purchasing, shared services, staff education, health information technology, loans/financial resources, recruitment services, and performance improvement services.

In addition, CAHs reported on the planning, development, and implementation of the Wyoming Critical Access Hospital Network (WCAHN). Fourteen CAHs are reportedly members of WCAHN. Information related to the WCAHN is included in Section 5 below.

J. COMMUNITY HEALTH PROVIDERS' WORKING RELATIONS WITH AND PERCEPTIONS OF CAHS

Community health providers are considered key to the success of all rural health services. Therefore, as part of the Community Care Health Provider Survey, healthcare providers working in CAH communities were asked to report on their knowledge of the local hospital's CAH status, working relations with their local CAH, referral patterns, involvement in community health planning and community health collaborations, and their overall opinion of CAHs. Community health providers report that 61 percent (n = 25) are aware their local hospital is a CAH and 33 percent were involved in the hospital's decision to convert. In addition, 82 percent report they have a working relationship with their local CAH and categorized their relationship as "very strong" (37 percent), "strong" (26 percent), "average" (32 percent), "weak" (5 percent), and "very weak" (0 percent). Of the community health providers surveyed, 91 percent report they refer or transport an average of four patients per month to the local CAH. When asked if their referral patterns have changed over the past five years,

21 percent of survey respondents report "yes". Of those reporting "yes", one community health provider report they are referring more to their local CAH because the hospital facility and physician staffing have "greatly improved" and two report they are no longer referring patients because of changes in services (e.g., surgery) at the CAH.

Community health providers were also asked about their involvement in community health planning activities and local health collaboratives. They report 20 percent are involved in community health planning through serving on the hospital board and working with local public health. Twenty-two percent report they are involved in local health collaboratives, such as: serving on the county board of health, local human resource council, or coalition for domestic violence and working on committees that are addressing disaster planning and flu pandemic planning. Finally, community health providers were asked to indicate their overall opinion of their local CAH and the care it provides. They report their overall opinions as: "very good" (17 percent), "good" (43 percent), "average" (39 percent), "poor" (0 percent), and "very poor" (0 percent).

K. CAH POST-CONVERSION OPPORTUNITIES, CHALLENGES, AND NEEDS

~~For Flex Program planning purposes, a~~All Flex Program stakeholders interviewed or surveyed during the evaluation process were asked about CAH opportunities, challenges, and needs. Challenges reported by CAH staff as part of the site visits and as part of the CAH administrator key informant interviews are included here along with those identified by community members~~; , while~~ those reported by state Flex Program stakeholders are reported in Section 8 of this report.

"Success breeds success."

- CAH Staff

CAH Opportunities

CAH staff were asked to report on programs opportunities which could advance other CAHs, programs or initiatives that have developed since conversion to CAH status. They report:

"We have a physician crisis because of high turnover. A few new come on and then they leave."

- CAH Staff

- Increasing their market share through marketing the importance of the hospital, as indicated by their CAH status
- Requiring all hospital employees to participate in at least one community volunteer opportunity and report that experience to the hospital
- Providing CAH-specific technical assistance to address swing-bed program issues

CAH Challenges

During the CAH site visits and CAH administrator interviews, CAH staff were asked to report their hospital's greatest challenges and concerns. They report the following:

Human Resources:

- Staff training
  - Training for business office staff
  - Nurse management

  - Health information technology (HIT) training
  - Clinical/trauma training
- Services through telemedicine
- Hospital board education
- Cross border issues
- High physician turnover
- Salaries and benefits offered by competing employers (e.g., McDonalds)
- State's low unemployment rate which results in higher competition for workers
- Recruitment and retention of healthcare providers
  - Physicians
  - Specialists (orthopedic surgeons, OB/GYN)
  - Nurses
  - Pharmacists
  - Housekeeping staff
  - Long-term care staff

"They [board members] don't like it when CEOs are away from the hospital. They don't understand this."

- CAH Staff

"Mental health. We do a fair amount of patient holds, sometimes for a long time. We don't have staff trained to treat patients. It's a horrible system."

- CAH Staff

<u>Financial:</u>

- Access to capital
- Increase in charity care
- Maximizing reimbursement
- Decline in inpatient acute care demand
- Increase in charity care/uncompensated care
- Lack of/limited market share

<u>Other:</u>

- Health insurance affordability
- Lack of mental health services
- Lack of pediatric services
- Increase in demand for mental health services
- Pending changes to the state's malpractice laws
- Declining population
- Implementing a swing-bed program
- Negotiating with preferred provider organizations
- Workplace health issues (e.g., mining and workplace injuries)
- HIT infrastructure issues
- Concern regarding expanding the CAH program to hospitals larger than 25 beds
- Substance abuse
  - Illegal drugs

"Pretty much everything can come together if we can find the people to do the job [referring to staff recruitment issues]."

- CAH Staff

  - Alcohol
  - Prescription drugs
  - Teens

- Health promotion/disease prevention/chronic disease management
  - Diabetes
  - Chronic pain/pain management

Complimenting these challenges identified by CAH staff are those identified through the Community Health Ceare Provider Survey by community healthcare providers. Healthcare providers working in CAH communities were asked to identify their community's greatest health issues. They report the following:

- Fear of change
- Transportation
- High rate of uninsured
- Reimbursement/funding
- Healthcare access
- Recruitment and retention of healthcare providers, including nurses
- Lack of specialists
- Family practice physicians who are working beyond their training and skills
- Low wages
- Healthcare costs
- Lack of reimbursement for some healthcare professionals (e.g., mental health)
- Pain management
- Stress
- Prescription drug abuse
- Access to training for healthcare staff
- Aging population
- Poor hospital management
- Deteriorating infrastructure
- Declining local economies

Recommended Changes to the Flex Program:

CAH staff were asked to make recommendations about how they would like to see the Flex Program change to better meet their needs. They report the following recommended changes:

- Communicate Flex Program activities and information to stakeholders
- Develop a means to sustain Flex Program activities and support for CAHs, even if federal funding is no longer available
- Establish HIT as a Flex Program priority
- Support HIT education for CAHs, in particular information on the

"Since I don't know who they are [Flex Program], they need to do a better job communicating what they are doing and how we can be involved."

- CAH Staff

different types of HIT and what is applicable for small rural hospitals

- Support community needs assessments for CAHs with outdated needs assessment data
- Support performance improvement related activities at the individual CAH level
- Work more closely with survey and licensing staff to provide updates at WCAHN meetings, address survey and licensing needs that arise in CAHs, and to track survey and licensing issues in CAHs so they can learn from one another and share best practices
- Work more closely with the state's fiscal intermediary to obtain information in a more responsive manner and to resolve issues as they arise
- Make regular visits to CAHs to connect with staff, provide program updates and other relevant information, and to better understand the needs and challenges of CAHs and the communities they serve
- Develop and make available toolkits or webinars to assist with preparing for and addressing survey and licensing needs
- Pilot health promotion and disease prevention programs in CAHs
- Support hospital service expansion opportunities (e.g., mobile MRI and CT)
- Assistance with CAH trauma designation needs

"We do everything we can to keep prices down but that never seems to be enough."

- CAH Staff

Section 4: Quality Improvement

The Wyoming Flex Program has supported CAH related quality improvement initiatives over the past several years, such as grants to support CAH specific quality improvement projects, joint QI initiatives with Mountain-Pacific Quality Health Foundation (the state's Quality Improvement Organization), data collection through QHi (a multi-state, data collection, and benchmarking initiative), and recent QI needs assessments. To better understand CAHs' use of and perceptions of these initiatives and any related outcomes as well as to identify CAHs' quality improvement needs, CAH staff, as part of the CAH site visits and CAH administrator interviews, were asked to report on: 1) QI needs being addressed, 2) QI projects being used to address QI needs, 3) examples of changes in hospital operations aimed to improve QI, and 4) on-going QI needs/challenges.

"Sometimes we're swimming in data and feel like we have no time to respond to any of the data."

- CAH Staff

None of the CAHs indicate Flex Program supported quality improvement initiatives improved quality of care in their hospital. However, most CAH staff spoke favorably of the work performed by the Mountain-Pacific Quality Health Foundation, but were unable to report project outcomes. Therefore, CAHs were asked to report on their quality improvement needs, projects and tools being used, and their hospital specific needs/challenges. All are reported here.

"I think QHi is a pain in the butt. But it's just one more report that she [QI coordinator] needs to do."

- CAH Staff

QI Needs Being Addressed

All CAHs report having quality improvement programs in place. Staff most frequently reported having quality improvement initiatives in place for:

- Medication errors/safety
- Falls
- Pneumonia

QI Projects Most Frequently Identified

- 5 Million Lives Campaign
- Projects through Mountain-Pacific Quality Health Foundation
- CMS, Hospital Compare (100% participation)
- Colorado Hospital Association – Wyoming Hospital Association shared Databank
- System-based QI
- QHi

"I think I'm the only one submitting data to it (QHi). I've about talked blue in the face about it."

- CAH Staff

Quality Improvement Needs/Challenges

- Quality issues between and across hospital departments

- Opportunities to compare CAHs' quality indicators in the state
- QI leadership training
- Opportunities to demonstrate how quality improvement has a cross-facility impact

QHi

QHi is an on-going initiative of the Flex Program. QHi participation data (until 2007) were available, as was information collected through discussions with CAH staff. Available data reflects that in October 2006, ten CAHs had signed agreements to participate in QHi. By December 2006, six CAHs were submitting data on a monthly basis. In January 2007, four CAHs submitted data. February 2007, indicated two CAHs submitted data. In 2008, when asked during the CAH interviews, three CAHs report they are submitting data to QHi. Although most CAHs report they are not reporting data to QHi, a number of CAHs indicate it is a worthwhile project. They have, however struggled with having the staff resources and/or staff turnover to submit data.

Other QHi related Comments CAH staff report:

- Some CAH staff report that although they have other QI data collection systems, QHi is "more focused" or "geared towards" quality indicators while the other systems are more focused on utilization review and financial indicators
- Some CAHs express a need to "demonstrate the value" of QHi to users. Others indicate a need to revisit the use of QHi, particularly after a neighboring state advocated for the use of QHi and then abandoned the project.

Section 5: Networks

Networks are typically defined as horizontal or vertical, formal or informal, and system or community-based. Networks of all types (both formal and informal) exist in Wyoming. As with some other states, Wyoming has some hospital systems (e.g., Banner Lassen) that own or operate hospitals in the state. Unique to networking in Wyoming is that most CAHs report their primary referral and transfer hospitals are located in other states. This may be attributed to the state having no Level I trauma centers in Wyoming, CAHs' historical referral patterns, and/or CAHs being geographically closer to hospitals located in other states (e.g., Colorado, Nebraska, Montana, South Dakota, and Utah).

Table 2: Network Types

Type	Description
Horizontal Network	Relationship between the same classifications of healthcare providers (e.g., a network of hospitals or a network of nursing homes).
Vertical Network	Relationship between varieties of classifications of healthcare providers (e.g., hospitals, nursing homes, clinics, and home health).
Formal Network	A formal written agreement that includes a start and end date and typically includes an exchange of resources between the network members.
Informal Network	An informal spoken or understood agreement between participating members.
System	A hierarchical network of members that includes a lead/coordinating entity with subsidiary type members that may be owned, managed, and/or affiliated.
Community-based	Locally owned, operated, and/or managed.

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NETWORK ACTIVITIES

Hospital networks in Wyoming have a history that precedes the Flex Program, yet some have evolved since small rural hospitals converted to CAH status. Hospitals that converted to CAH status were required to have at least one formal network agreement with a tertiary center for patient referrals and transfers. All CAHs report they had a formal agreement in place when they converted to CAH status. Although required as part of the CAH certification requirements, it is unclear whether current/active network agreements are in place at all CAHs.

"There's always a core group of 6 – 7 that are actively involved [in WCAHN] and others that never participate."

- CAH Staff

In 2005, the Wyoming Flex Program started exploring the possibility of establishing a network of CAHs in the state. In 2006, steps were taken and the Wyoming Critical Access Hospital Network (WCAHN) was established. WCAHN is comprised of 14 CAHs in Wyoming, formed for the purposes of sharing resources, continuing education, promoting operational efficiencies, and improving healthcare services for member hospitals and the rural communities they serve.

CAHs were asked questions about the WCAHN, in particular strengths, challenges, needs, and next steps. They report the following:

WCAHN Strengths:

- Opportunity to network and share information
- Opportunity to address shared issues, such as workforce recruitment and retention issues
- New leadership through the hospital association
- Network staff who "listen" to members
- Potential to serve as a building-block for CAHs in the state
- Starting to establish a telehealth network in the state which will result in communication tools and the ability of CAHs to communicate via video conferencing

WCANH Challenges:

- Lack of involvement by all hospital administrators
- Turnover in CAH administrators
- Turnover in WCAHN leadership
- Turnover in Flex Program staff
- Most CAHs refer patients to hospitals in border states with limited common referral patterns
- Few hospitals are submitting data to a common quality improvement data collection site

WCAHN Needs/Suggested Next Steps:

- Explore group health insurance purchasing
- Develop a mechanism to better share best practices between CAHs
- Establish a "rural voice" for CAHs in the state
- Increase communications between stakeholder organizations
- Better utilize technology for communication purposes
- Align the WCAHN's strategic plan with the state's rural health plan
- Explore a common health information system/electronic medical record, in particular for those CAHs that are not a part of a system or larger management organization
- Include referral hospitals in other states in the WCAHN discussions
- Enhance training opportunities
- Continue to have open communications between the WCAHN and the Wyoming Flex Program/State Office of Rural Health

Other:

- A number of CAHs discussed the nurse management training program being developed by the WCAHN. They identified this as a possible "1st success" for the network

- CAHs report there was a disconnect between the WCAHN planning process and the state rural health plan development process. This reportedly created some confusion and redundancy in efforts
- Most CAHs commented on the "slow" start to the WCAHN. -Although many acknowledge that little progress has been made, they are hopeful that the network can assist them in meeting some of their challenges
- All CAH staff interviewed discussed the activities and history of WCAHN, noting they believe recent WCAHN strategic planning and planned workforce development initiatives are beneficial. In addition, they also noted barriers to the network's development, such as WCAHN staff turnover, CAH leadership staff turnover, and the geographic distances between CAHs. All CAHs report being supportive of the development of the WCAHN

Section 6: Emergency Medical Services (EMS)

Wyoming's Flex Program has supported EMS through informal arrangements with the Wyoming Department of Health, Office of EMS. These arrangements have included support for: EMS System Enhancement Awards, instructor payments for EMT-Intermediate classes, annual trauma registry site licenses fees for all hospitals in the state, EMT and nurse continuing education opportunities, trauma registry training, subsidies for statewide and regional trauma meetings, medical director training, and training as part of the Rural Trauma Team Development Course (RTTDC) for hospital and EMS personnel. The Flex Program has supported an average of $90,803 per year (22.9% of annual state Flex Program funding) in EMS activities to complete this work.[13] Although no national data exists to determine whether this level of EMS support is comparable to other states, data from eight other states indicate this is a significant level of support when compared to other states.[14]

EMS System Enhancement Awards (Mini-Grants Program)
The EMS System Enhancement Awards (aka EMS Mini-Grants Program) have been a significant component of the state's Flex Program as they have accounted for approximately 10.9 percent of the state's total Flex Program funding. As indicated in Chart 3, EMS System Enhancement Awards were an on-going Flex Program activity that realized changes in funding over the years and they were eliminated as part of the 2007 state Flex Program grant year. The grant program was established in 1999 as an opportunity for local EMS agencies to engage in contractual arrangements to purchase equipment and/or supplies. When possible, joint purchasing arrangements were made through the Office of EMS which allowed local EMS agencies to purchase supplies and equipment at a reduced rate.

Seventy-nine ambulance services in Wyoming were funded $388,339 (1999 – 2006) through the EMS System Enhancement Awards. A total of 302 grants were made to local EMS agencies using this process. Annual grants to local EMS agencies averaged $1,300 and ranged from $125 to $2,725 per year, per EMS agency. Considering the grant program over all seven grant years:

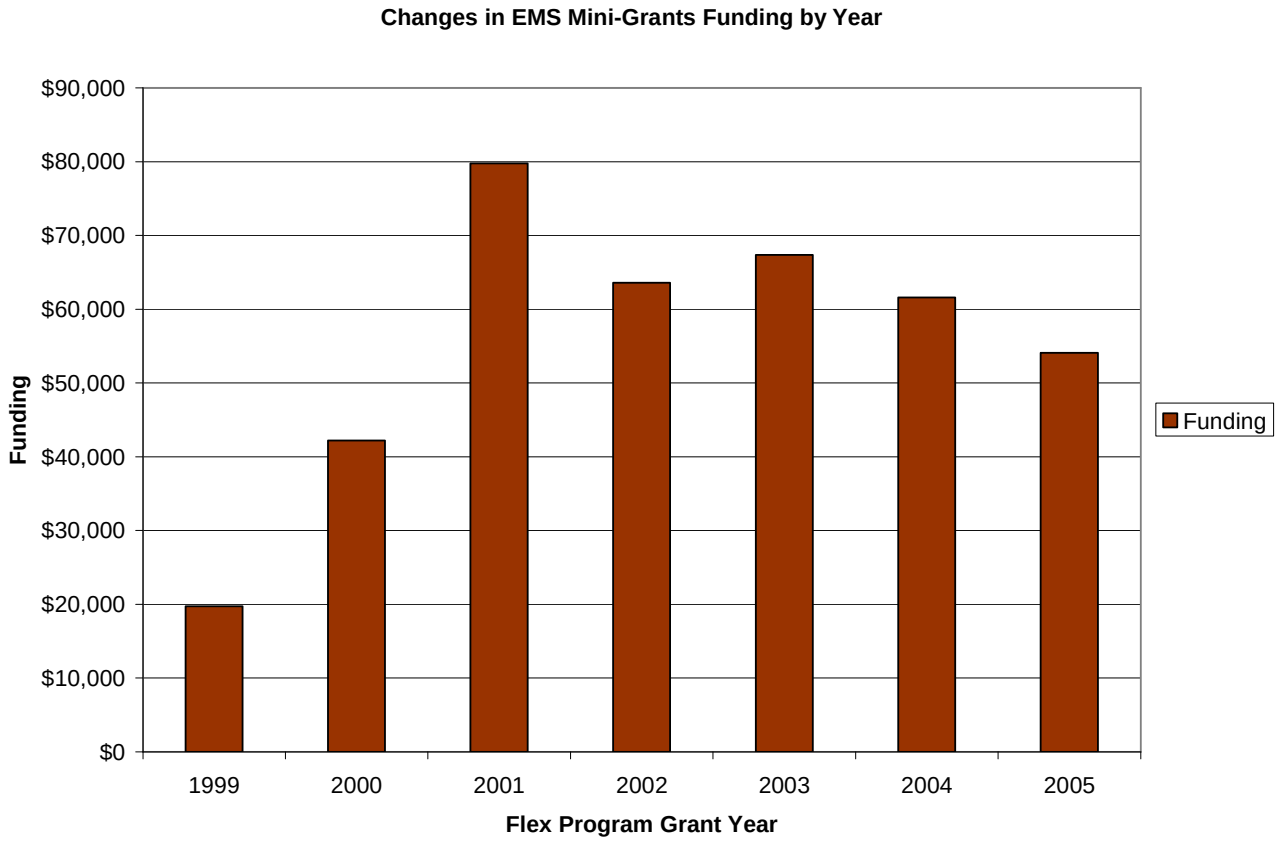
- The highest funded ambulance service was awarded $10,345 as part of five grant years
- The lowest funded ambulance service was awarded one $500 grant
- Three ambulance services received funding all seven grant years averaging $8,568 in total grant funding per ambulance service or a total of $25,703
- The five highest funded ambulance services (6 % of ambulance services funded) received $48,020 in funding or 12.4 percent of total ambulance service funding over the seven year period
- Most grant funding was awarded to EMS agencies located in rural areas

[13] Annual average is based on Flex Program grant years 2002 – 2006.

[14] Rural Health Solutions has conducted Flex Program evaluations in eight states.

- At least 13 of 14 ambulance services located in CAH communities received grants through the mini-grants program.[15]

Chart 3: Annual Changes in Funding for EMS System Enhancement Awards



EMT-Intermediate Courses

Instructor and local coordinator payments for EMT-Intermediate classes have been funded through the Flex Program over the past five years and made available through the Office of EMS. The intent of the training is to provide easy access to advanced life support training courses by offering them in rural communities. Although no data is available on how many EMT-Intermediate staff have been trained through this program, offering this training locally has reportedly resulted in approximately 95 percent of all ambulance services in Wyoming being able to provide intermediate life support services.

[15] Due to the data identifiers used for each ambulance service and the lack of city names for some sites funded, it is unclear whether one CAH community received funding.

Trauma System Support
Regional and state trauma meetings are supported through the Flex Program by funding and subsidizing participants' travel costs, meeting room rentals, and supplies. Flex Program funding also pays for all hospitals' annual trauma registry site license renewals, technical support, and software upgrades. Although these are on-going Flex Program funded activities, no measurable outcomes were reported because of this work. It could be assumed that more rural EMS agencies are participating in state trauma meetings because of the transportation subsidies; however, no data has been collected to support this hypothesis.

To better understand the impact of the Flex Program on local, regional, and state EMS, CAH and local EMS staff and state EMS stakeholders were asked questions about EMS as part of the CAH site visits, CAH administrator key informant interviews, and state stakeholder interviews. They report the following:

- All EMS stakeholders interviewed were familiar with CAH status
- All local EMS stakeholders were aware that their hospital is a CAH
- No local EMS agency was aware of the Flex Program
- No EMS agency was aware the EMS System Enhancement Awards were a part of the Flex Program
- No CAH staff with hospital-based EMS were aware the EMS System Enhancement Awards they had received were part of the Flex Program

"I thought that grant came from the state EMS."
- EMS Staff

EMS STRENGTHS AND CHALLENGES

Evaluation participants were asked to report on Wyoming's rural EMS strengths and challenges/needs, they indicate the following:

"We don't have any EMS issues. I think they [EMS] are well run and are well respected by the community."
- CAH Staff

Strengths

- Most CAH staff, local EMS, and state EMS staff report EMS is functioning well and they have good working relations with other healthcare providers
- Some CAHs are doing joint training with local EMS (e.g., IV training)
- Community knowledge of local EMS reportedly has improved somewhat over the past five years

"We could actually do more with EMS. We work well together and we know there are more opportunities to partner and leverage our resources."
- CAH Staff

Challenges

- On-going difficulty recruiting and retaining staff
- Increasing training requirements for EMS staff, ~~in~~ particularly~~,~~ for volunteers
- Run data that continues to be written on run sheets and then re-entered electronically

- Although EMS agencies are collecting run data, they are reportedly not using the data for QI purposes
- EMS agencies have limited to no clinical quality improvement initiatives in place.
- Changing community demographics
- EMS member accountability, in particular as it relates to volunteers reporting run data, preparing ambulances for future runs, re-stocking ambulances, and attending local EMS meetings
- Lack of access to HIT and HIT infrastructure needs (e.g., internet access at local EMS agencies)
- Increasing gas prices
- Increasing maintenance costs for ambulances
- Consumers' limited knowledge about local EMS
- Consumers' increasing demand for EMS/increasing volume across much of the state
- Decline in community resources which translates into a decline in local resources (e.g., tax revenue) dedicated to local EMS
- EMS reimbursement
- Increasing demand for transports
- Local governments' lack of involvement in EMS planning and development
- Local governments' lack of understanding about EMS
- EMS staff training needs
    - Inconsistent (e.g., 535 certified EMS instructors teaching differently)
    - Need for pediatric training
    - EMS operations/performance improvement training

"We have great relations with EMS. EMS does a good job. We have done some IV training together and have talked about other training opportunities."

- CAH Staff

Section 7: Evaluation Activities

An examination of Wyoming Flex Program's evaluation work occurred by looking at past Flex Program evaluation documentation, survey instruments, and other items as available. Using this information, it was determined that Wyoming has evaluated different aspects of its Flex Program over the past nine years. However, this evaluation work has been limited. Most evaluation work has occurred at the activity level (e.g., conference satisfaction surveys). A survey of CAH administrators was conducted in 2005 to determine their satisfaction with the Flex Program. The current Flex Program evaluation, as reflected in this report, is the first full Flex Program evaluation completed as part of the Wyoming Flex Program.

Flex Program meeting evaluation data from earlier program years indicate meeting participants have been very satisfied with the meetings supported through the Flex Program, while overall Flex Program satisfaction data indicate mixed results.

Flex Program meeting evaluation summaries from three events were reviewed and included in this evaluation process. All meetings were held as part of the Wyoming CAH Network: October 19, 2005; November 10, 2005; and February 10, 2006. Table 3 reports participants' survey data from each of the three meetings.

A multi-purpose survey of CAHs was conducted in April 2005 by the Wyoming Flex Program. The survey was intended to provide evaluation information from CAH administrators in the following areas: 1) satisfaction with Flex Program technical assistance, 2) satisfaction with the CAH conversion process, 3) importance and identification of EMS issues, 4) satisfaction with regional Rural Health Conference, 5) trend data on hospital operations, 6) impact of the Flex Program on communities and CAHs, 7) CAH needs for quality improvement technical assistance, and 8) CAH needs for training. The survey was mailed and the response rate was 64 percent (9 of 14). Survey findings were reported in the Medicare Rural Hospital Flexibility (Flex) Program 2005 Critical Access Hospital Survey, Summary of Results. Significant survey findings indicated that 33 percent of respondents reportedly received no technical assistance from the Wyoming Flex Program during the CAH conversion process. Also survey results indicated five of the nine CAHs were either somewhat satisfied or not satisfied with the CAH application process noting delays and issues within the Office of Rural Health. Open-ended comments about the Flex Program and its effect on communities and CAHs to note include:

Community:

- "There is no longer a fear that the hospital will be closing. As more people use the hospital, [the hospital] can hire more personnel. Equipment that needed replaced years ago can be purchased/replaced. This enhances the quality of care given to patients"
- "Stabilized the financial health of our hospital which ensured the long-term viability of healthcare services for the community"
- "EMS training and grants have benefited the Hospital District"

Hospital:

- "It allowed us to bring in a consultant to help understand how to do things under Critical Access for reimbursement and compliance"
- "It has given [hospital] funding to do a study in going CAH – also a charge master review previous to going CAH"
- None so far. Overall though things have improved"
- It has provided some funds for education and HIPAA compliance"

Other Comments:

- "I think they do a good job"
- "Again, I would strongly recommend that the Flex Program contract with the WHA to enhance CAH education as the State is not doing this and the majority of hospitals in Wyoming are CAHs"

Current Activities (2007 – 2008 grant year):
2007- 2008 Flex Program grant evaluation activities are reflected in this report.

Table 3: CAH Networking Meeting Survey Findings

Question	10/19/05 Average Response	11/10/05 Average Response	2/10/06 Average Response	Average Response for All Three Meetings
The meeting achieved the stated purpose and outcomes related to objective 1*	5.0	4.9	4.3	**4.7**
The meeting achieved the stated purpose related to objective 2**	5.0	4.9	4.4	**4.7**
The meeting achieved the stated purpose related to objective 3***	4.9	NA	NA	**4.9**
The content of the meeting was useful to achieving the stated purposes and outcomes	5.0	4.9	4.3	**4.7**
Facilitation of the meeting was helpful to achieving the stated purposes and outcomes	4.9	4.8	4.25	**4.6**
The main speaker demonstrated thorough knowledge of the subject	5.0	NA	4.4	**4.7**
The materials were relevant and useful	4.9	4.8	4.3	**4.6**
Total Number of Attendees	**9**	**12**	**12**	**11**

**Indicates: Objectives were to draft a mission statement (10/19/05), review and update action plans (11/10/05), and establish a price agreement for Milliman (2/10/06) for the WCAHN.*

***Indicates: Objectives were to prioritize WCAHN activities (10/19/05), identify next steps (11/10/05), and present activities satisfaction tools (2/10/06) for the WCAHN.*

****Indicates: Objectives were to develop an action plan for WCAHN (10/19/05), present content that was useful (11/10/05), and present information related to network activities (2/10/06) for the WCAHN.*

Section 8: State Stakeholder Interviews

Seven state Flex Program stakeholders were interviewed and asked questions about the development, implementation, strengths, weaknesses, and future of Wyoming's Flex Program.[16] None of those interviewed indicate they were involved in the program since its inception and one was familiar with all of the goals and activities of the Flex Program. Findings from those interviews are reported here.

Program Administration

The Wyoming Department of Health, Rural and Frontier Health Division, Office of Rural Health, administers the Flex Program. The Program has no dedicated Flex Program Coordinator; rather, the Flex Program Coordinator is a shared position with Manager of the Wyoming State Office of Rural Health. In addition, there had been regular staff turnover in the position, which has stabilized. Regardless, this turnover has reportedly had an impact on the program and its development.

"I think the Flex Program is improving and that has a lot to do with keeping staff [Flex Program staff]."
State Stakeholder

Program Perceptions

State Flex Program stakeholders discussed a variety of strengths, weakness, and rural health needs as part of the state stakeholder interviews. Five of the state stakeholders report they are familiar with the Wyoming Flex Program. However, three stakeholders interviewed were aware of Flex Program activities outside of those in which they are directly involved. There were few areas where consensus was reached in terms of Flex Program accomplishments and outcomes. Information related to state stakeholders' perceptions of the Wyoming Flex Program is summarized here.

"We all like one another and we are not afraid to express our opinions."
State Stakeholder

<u>All state level stakeholders agree that</u>:

- They are aware there are CAHs in Wyoming
- The stabilization of Flex Program staff in the Office of Rural Health is important to the advancement of the Wyoming Flex Program
- The Wyoming Office of Rural Health and Wyoming Hospital Association are key Flex Program stakeholders

<u>Most state level stakeholders agree that</u>:

- Flex Program stakeholders work well together
- The Wyoming Department of Health, Rural and Frontier Health Division, Office of Rural Health, Flex Program has reportedly made some important organizational changes which are improving the Flex Program

[16] For evaluation purposes, Rural Health Solutions considers organizations to be state level stakeholders if they are identified in the legislation that created the Flex Program and/or if they are identified as a Flex Program stakeholder by the State Office of Rural Health. A list of Wyoming Flex Program state stakeholders are included in Table 1 on page 8.

- The Flex Program has done a good job in recent years at obtaining information and input from state and local Flex Program stakeholders
- They would like to improve communications between Flex Program stakeholders through more regular, formal communications opportunities
- Most Flex Program communications occur from one stakeholder to another vs. communications between stakeholders
- The greatest success of the Flex Program has been converting small rural hospitals to CAH status.
- The WCAHN is a significant opportunity for the state's Flex Program
- CAHs and local EMS have benefitted from the Flex Program
- Access to health services in Wyoming is a growing concern
- The Flex Program has done a "good job" at including state stakeholders in Flex Program funding decisions
- Flex Program funding decisions are not made using a formal decision-making process with broad, coordinated, stakeholder input

Some state level stakeholders agree that:

- The state rural health plan development process was valuable and/or beneficial
- Stakeholder organizations interact infrequently, so when there are staff changes it has a significant and negative impact on the program
- The Wyoming Hospital Association needs to be a more active partner in the Wyoming Flex Program
- Their organization should make it a priority to be more engaged in the Flex Program
- Given the rural and frontier nature of Wyoming, the unique roles of the Wyoming Hospital Association and the WCAHN continue to be unclear
- The Flex Program should identify emerging program partners to foster health promotion and disease prevention in rural communities and to address workforce issues

Stakeholders report the greatest issues impacting rural communities as:

- Recruitment and retention of healthcare providers
- Competition for staff due to the increase in economic development
- Geographic access to health services

Stakeholders report the greatest issues impacting rural health as:

- Recruitment and retention of healthcare providers
- Staff turnover
- Supporting, sustaining, and developing the local health services to meet current and future population needs
- Access to capital
- Hospitals that continue to be financially fragile
- Staff training

- Management/leadership
- Clinical skills in areas with limited patient volume

Stakeholders recommend that the Wyoming Flex Program:

- Provide opportunities for grant writing training for CAH staff
- Focus on recruitment and retention of health services staff
- Support telemedicine expansion opportunities
- Remain flexible to meet the unique needs of each CAH
- Support CAH marketing and public relations activities, focusing on the role of CAHs and the communities they serveImprove and formalize program communications activities
- Identify emerging program partners to foster health promotion and disease prevention in rural communities and to address workforce issues
- Find ways to further encourage CAH participation in Flex Program funded activities, workshops, and meetings
- Support the expansion of tele-training and tele-networking opportunities

Section 9: Summary of Key Findings

The Wyoming Flex Program Evaluation resulted in many program findings noted throughout this document. Key program findings are summarized and highlighted here.

FLEX PROGRAM IMPLEMENTATION

- During the past nine years, the Wyoming Flex Program obtained $3,564,491, or an average of $396,055 per year, from the Health Resources and Services Administration, Office of Rural Health Policy to implement the Flex Program in Wyoming
- Wyoming ranks 34th of 45 states nationally in terms of the federal funding that the Flex Program has received over the nine-year lifespan of the Flex Program
- Wyoming ranks 16th of 45 states nationally in terms of the federal funding the Flex Program has received per CAH ($254,067/CAH)
- The Wyoming Flex Program currently addresses all the national Flex Program goals
- A Wyoming Rural Health Plan was created and approved by the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services - CMS) in March 2000
- In 2007, Wyoming started working on a new Wyoming Rural Health Plan. It is planned for completion in October 2008
- CAHs report they support the development of the 2008 state rural health plan
- The Wyoming Flex Program has had extensive staff turnover since the programs inception; however, this has stabilized in the last year
- Flex Program staffing has ranged from .62 FTE (full-time equivalents) to 1.12 FTE at the Wyoming Department of Health
- Wyoming Flex Program funding has been directed to: staff salaries and benefits (11.9%); travel costs (5%); EMS activities (22.7 %); CAH support, performance improvement, and network development (26.7%); quality improvement activities (8.4%); indirect charges (9.3%); and other program costs (16%)
- Some CAH staff report their hospital received technical assistance through the Flex Program to convert their hospital to CAH status
- Most CAH staff report their hospital received technical assistance from other CAHs to convert their hospital to CAH status
- CAHs and Flex Program stakeholders report significant Flex Program improvements in the past two years

CAHs

- There are 14 CAHs in Wyoming or 51.9 percent of the state's hospitals
- One small rural hospital is in the process of converting to CAH status and one additional hospital is eligible for conversion

- Eleven of Wyoming's CAHs meet the federal geographic criteria of the hospital being 35miles or 15 miles in mountainous terrain or areas only served by a secondary road from the next nearest hospital
- Most CAHs in Wyoming refer and transfer their patients to tertiary centers in other states
- All CAH staff report their decision to convert to CAH status was primarily a financial decision
- Most CAHs report receiving funding through the Flex Program to complete community needs assessments, financial feasibility studies, and network agreements
- Most CAHs report the CAH conversion process took approximately one year
- All CAH administrators report their hospital's financial status has improved since the hospital converted to CAH status; however, differences in improvement vary throughout the state
- 82 percent of community healthcare providers surveyed report they have a working relationship with their CAH and categorized their relationship as "very strong" (37 percent), "strong" (26 percent), "average" (32 percent), "weak" (5 percent), and "very weak" (0 percent)
- Community healthcare providers surveyed report their overall opinion of their local CAH as: "very good" (17 percent), "good" (43 percent), "average" (39 percent), "poor" (0 percent), and "very poor" (0 percent)
- All but one CAH that started Milliman through the Flex Program continue to use the program.
- CAHs report Milliman has improved their admission and discharge processes
- Most CAH staff report that they have experienced a notable increase in Flex Program support over the past two years
- While some CAHs have eliminated health services, all CAHs have added and upgraded the health services available at the hospital
- CAHs identified a number of challenges and issues that could be addressed as part of the Flex Program, in particular those related to human resources development and performance improvement
- All CAHs are either planning for or implementing an Electronic Medical Record (EMR)

NETWORK DEVELOPMENT

- Unique to networking in Wyoming is that it appears that when a patient referral or transfer is necessary, CAHs refer and transfer most of their patients to tertiary centers located in other states
- CAHs report the greatest success of the Wyoming Flex Program is the development of WCAHN
- Although CAHs report few outcomes have resulted because of the WCAHN, they support its development and believe it should continue to be an important part of the state's Flex Program
- CAHs support the use of and focus on HIT to enhance and advance the goals of the WCAHN

QUALITY IMPROVEMENT

- All CAHs report having quality improvement initiatives in place in their hospital

- Most CAHs report the work of Mountain-Pacific Quality Health Foundation is improving quality of care in hospitals
- None of the CAHs indicate that Flex Program supported quality improvement initiatives have improved quality of care in their hospital
- Some CAHs are strong advocates for the QHi initiative and believe it is a tool that will support QI while others report the initiative should be reconsidered
- All CAHs report to CMS' Hospital Compare

EMS

- The Flex Program has supported an average of $90,803 per year (22.9% of annual state Flex Program funding) in EMS activities
- Seventy-nine ambulance services in Wyoming were funded $388,339 through the Flex Program's EMS System Enhancement Awards
- A total of 302 grants were made to local EMS agencies through the Flex Program's EMS System Enhancement Awards
- The Flex Program supports EMT-I training in rural communities
- 95 percent of Wyoming EMS agencies offer intermediate EMT services

EVALUATION

- Wyoming has evaluated different aspects of its Flex Program over the past nine years; however, this work has been limited
- Most Flex Program evaluation work has occurred at the activity level (e.g., conference satisfaction surveys) while others occurred as part of a broader program objective (e.g., survey of CAH administrators to determine their satisfaction with the Flex Program or outcomes associated with the diabetes tele-education program)
- Current evaluation findings are consistent with some of those identified through past program evaluations
- The current Flex Program evaluation, as reflected in this report, is the first full Flex Program evaluation completed as part of the Wyoming Flex Program

Section 10: Recommendations

The following recommendations are based on the data, documentation, interviews, observations, and analysis that occurred through the Wyoming Flex Program evaluation. Recommendations are intended to assist Wyoming in developing and improving its Flex Program to better meet program stakeholder (state level stakeholders, CAHs, small rural hospitals, EMS) needs and achieve the goals of the national program.

Since the Flex Program is administered by the Wyoming Department of Health, Rural and Frontier Health Division, Office of Rural Health, the evaluation recommendations are primarily targeted here. However, recommendations should also be seen as an opportunity for improvement by all Flex Program stakeholders, in particular: Wyoming Hospital Association, Wyoming Office of EMS, local and regional EMS, and CAHs. Recommendations are not reported in order of priority.

1) PROGRAM INFORMATION AND EDUCATION

Wyoming should continue to educate key program stakeholders about the Flex Program and its intended goals.

- Education should be incorporated into the program's strategic planning and communications related activities
- Education should re-engage stakeholders so they can be active program participants
- Education should focus on the rural health plan and its purpose, the role of EMS in the Flex Program, and coordination between program activities/initiatives
- Education should account for the regular turnover in Flex Program stakeholder staff, in particular those located in CAHs
- Information should be shared on a regular basis (quarterly perhaps) to better meet the needs of stakeholders when they experience staff turnover

2) STRATEGIC PLANNING

Wyoming should continue its formal, on-going Flex Program rural health planning process.

- A strategic direction has been identified for the Wyoming Flex Program through its rural health planning process. In order to keep this momentum moving and to increasingly engage stakeholder involvement and buy-in, regular program planning should occur, preferably on an annual or bi-annual basis
- Flex Program stakeholders, including representatives of: CAHs; state, regional, and local EMS; Wyoming Hospital Association; Wyoming Office of Rural Health; WCAHN; Mountain-Pacific Quality Health Foundation; and others as identified should be included in the program planning process
- Given that the Wyoming Hospital Association is one of two organizations required to be involved in the Flex Program, while they have had limited involvement, specific attention should be made to engage them in the program
- Work towards leveraging the resources of all key Flex Program stakeholders to create efficiencies and advance common goals

3) COMMUNICATIONS

Wyoming should establish a formal Flex Program communications plan that reports on program activities, changes, and updates.

- Development of a Flex Program communications plan should be included as part of the state Flex Program strategic planning process
- Wyoming should develop its Web presence as part of its communications plan. Other state's Flex Program websites can be used as a resource for this work. Sites to consider include Texas, Minnesota, Wisconsin, Colorado, Illinois, and Oregon
- Development of a Wyoming Flex Program Annual Report should be considered as part of the Flex Program. An annual report will allow for a more efficient and effective means of communicating program goals, objectives, and outcomes locally, statewide, and nationally. An annual report can also serve as a key communication tool for those that are new to the Wyoming Flex Program, CAHs, and local EMS
- The Flex Program should facilitate communications between the Mountain-Pacific Quality Health Foundation and Darlene Bainbridge and Associates to assure there is no duplication between the organization's work and to best meet the needs of CAHs
- Regular site visits to CAHs and other local stakeholders should be a high program priority. This is particularly important given the regular staff turnover that has occurred in CAHs and the Flex Program
- Create technology-based communication opportunities for CAHs and local EMS. This may be in the form of webinars, video-conferences, or tele-conferences and can be used to address issues related to travel times between CAHs and EMS
- Create a Flex Program identifier or logo to be used on all materials supported through the Flex Program. A logo can assist with creating an identity for the program and better inform stakeholders of the activities funded through the Flex Program

4) HIT

Further the Use of Health Information Technology.

- Careful considerations should be made to how best use information technology (IT) and in particular health information technology (HIT) to bridge the geographic divide in Wyoming.
- Although some Flex Program stakeholders have extensive experience with HIT, others do not. Therefore, IT use opportunities, such as webinars, podcasts, and video conferencing presentations should be used to increasingly familiarize stakeholders with the tools and resources available.
- Many CAHs would like to see HIT as a key component of the Flex Program and WCAHN. Therefore, HIT planning and information gathering is needed to make advances in this areas.

5) PROGRAM ACTIVITIES

Changes should be made to the activities supported through Wyoming's Flex Program and some key issues should be resolved.

- A few urgent needs should be addressed by Flex Program staff, including: contacting survey and licensing staff to arrange for a presentation on the key areas and issues that survey and licensing are identifying in CAHs and that need to be addressed

- Wyoming's Flex Program should identify best practices in other states to address community health issues related to obesity, smoking, diabetes and other key community concerns. Flex staff in Wisconsin and Minnesota are good resources given the number local level projects targeting these issues that have been funded through their states' Flex Programs
- Wyoming should identify those EMS agencies that are CAH-based and 35 miles from the next nearest EMS agencies and encourage them to network and plan
- Wyoming should consider looking at the Rural Wisconsin Health Cooperative's electronic medical record model they are using for network CAHs. This may be a viable model to consider for some of Wyoming's smallest CAHs working collaboratively with CAHs in neighboring states
- Once all of the local EMS needs assessments are completed, the Flex Program, local, regional, and state EMS should engage in discussions focused on planning and addressing those identified needs. This could either be incorporated directly into the rural health planning process or it could be completed through a workgroup process. The Flex Program should consider engaging EMS experts from Tennessee in this process as indicated below
- EMS stakeholders, in particular local and state EMS representatives, should be invited to participate in Flex Program planning activities
- On-going communication is needed between EMS and the Flex Program. The communications needs of EMS should be included as part of the overall Flex Program communications plan
- Given that many CAHs are working to address similar issues, CAH staff should be supported and encouraged to network to address these issues

6) EVALUATION

Wyoming should continue to monitor and evaluate Flex program outcomes; however, this should occur within the context of program planning and implementation with predetermined objectives, strategies, and outcome measures as indicated in the Wyoming Rural Health Plan.

- Program measures and targets included as part of the state's rural health plan should be tracked and used to better measure and report program outcomes. This can be built into the program planning process and reported as part of the Flex Program's annual report
- Regular site visits should be made to CAHs and local EMS. Site visits should include discussions with a variety of key staff to assure all stakeholders are engaged in and aware of the Flex Program
- Monitoring of the financial status of Wyoming CAHs should occur. Data available on an annual basis from the Flex Monitoring Team can assist with this process
- For hospital/CAH data tracking purposes, use the hospital's city name versus the hospital's name because hospital names change making it difficult to track changes over time, particularly given the high turnover in staff
- Wyoming should report program outcomes to its stakeholders on an annual basis for reporting planning, development, and communications purposes